Attachment A-Initial Report

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Critical Incident

Part I: Initial Report

Note:

- This report form should be completed to report an unusual, unfavorable occurrence that: a) is not consistent with routine operations; b) has harmful or otherwise negative effects involving people w/disabilities, employees, or property; and c) occurs in a DDSN Regional Center, DSN Board facility, other service provider facility, or during the direct provision of DDSN funded services.
- Database records will be identified either by Consumer Name or Provider Name.
- If more than one consumer is injured in an occurrence, a separate Critical Incident report should be submitted for each consumer.
- Initial Report must be submitted in writing, via fax, to the DDSN Director of Quality Management within 24 hours or the next working day of the event or whenever staff first became aware of the incident (postmarked or fax dated within that period of time). Any vehicle accidents/vandalism incidents meeting the reporting criteria are to be reported in writing, via fax, to the DDSN Director of Quality Management within 24 hours of receipt of an estimate.

Provider/Regional Center Reporting Incident: _____

County: _____

District I: ☐ Midlands ☐ Piedmont ☐ **District II:** ☐ Coastal ☐ Pee Dee ☐

Type Facility: ☐ DDSN Contracted Provider ☐ DDSN Regional Center ☐ DDSN Operated Facility (Autism Program)

Date of Incident: **Time of Incident:** ☐ AM ☐ PM **Shift:** ☐ 1st ☐ 2nd ☐ 3rd

Residence of Consumer:	**Descriptive Location of Residence:**
☐ At home with family/guardian or in own home ☐ CRCF ☐ CTH I ☐ CTH II ☐ ICF ☐ SLP I ☐ SLP II ☐ Other (i.e., private boarding home) ☐ Unit @ Regional Center (ICF/MR)	(Example: Smith CTH I, respite caregiver, Pee Dee Center)
Location of Incident: (Check all that apply) ☐ At home with family/guardian or in own home ☐ CRCF ☐ Day Program ☐ CTH ☐ Program/Admin Operations ☐ SLP ☐ DDSN funded service ☐ ICF (ex., respite, waiver, etc.) ☐ Other ☐ Regional Center (ICF/MR)	**Descriptive Location of Incident: *** (Indicate unit name in Regional Center, provider operated facility name, i.e., Sunrise CTH II, address in community, respite caregiver home, enclave, work activity center, other--store parking lot, other-hospital)

* If incident occurred on the agency van or in the facility, specify the descriptive location using the provider name and incident type (Examples: Provider Name-Vehicle Accident, Provider Name-Vehicle Incident , Provider Name-Staff, Provider Name-Program/Admin, Provider Name-Vandalism or Provider Name-Facility Incident).

People Involved:

Name of primary consumer involved: _____
(In consumer to consumer situations, list victim as primary consumer & list other person(s) involved below)

Was primary consumer enrolled in the DDSN Waiver when incident occurred?
☐ Yes ☐ No ☐ Don't Know If yes, specify which waiver:
☐ MR/RD ☐ HASCI ☐ PDD ☐ Other:

Name(s) of Other Person(s) Involved/Affected: (Check one category for each person involved)

☐ Perpetrator (Consumer) ☐ Perpetrator (Staff) ☐ Other Consumer Name: _____
☐ Perpetrator (Consumer) ☐ Perpetrator (Staff) ☐ Other Consumer Name: _____
☐ Perpetrator (Consumer) ☐ Perpetrator (Staff) ☐ Other Consumer Name: _____
☐ Staff ☐ Witness ☐ Family ☐ Other Specify: Name: _____
☐ Staff ☐ Witness ☐ Family ☐ Other Specify: Name: _____
☐ Staff ☐ Witness ☐ Family ☐ Other Specify: Name: _____

Brief Description of Incident: *(Please enter summarized data only. Detailed documentation and attachments should be attached to the official record.)*

Type Incident & Category (Check all Categories that apply for each Type Incident checked):

Type Incident / Category	Consumer Directly Affected	Consumer to Consumer	Staff *	Facility or Program Operations Impacted
☐ Accidents	☐	NA	NA	NA
☐ Aggression/Assault	☐	☐	☐	NA
☐ Communicable Disease	☐	NA	☐	NA
☐ Criminal Arrest	☐	NA	NA	NA
☐ Elopement (Length of time :)	☐	NA	NA	NA
☐ Fall	☐	☐	NA	NA
☐ Fire	☐	NA	NA	☐
☐ Firearms/Weapons/Explosives	☐	☐	☐	NA
☐ Illegal Substances	☐	NA	☐	NA
☐ Injury	☐	☐	☐	NA
☐ Law Enforcement	☐	☐	☐	NA
☐ Major Medical	☐	☐	☐	NA
☐ Malicious use of profane or disrespectful language to consumers	☐	NA	☐	NA
☐ Medical Treatment (prescribed/recommended) not followed	☐	NA	NA	NA
☐ Medication Errors	☐	NA	NA	NA
☐ Motor Vehicle	☐	NA	☐	☐
☐ Property Damage (natural or unusual)	☐	☐	☐	☐
☐ Sexual Assault	☐	☐	☐	NA
☐ Suicide	☐	NA	NA	NA
☐ Theft - Money	☐	☐	☐	☐
☐ Theft - Property	☐	☐	☐	☐
☐ Other (Specify): Provide detailed information in narrative	☐	☐	☐	☐

** Incident occurred due to consumer action or consumer will be affected by this incident.*

The Management Review

Person Assigned to Review: _____ Title:_____

Reporting: If the incident was reported to another agency, please indicate which agency:

☐ DHEC ☐ DSS ☐ Ombudsman
☐ Law Enforcement ☐ Other: (Specify):

Reported by whom?_____ Title: _____

Immediate actions taken to protect the consumer:

Immediate action taken to secure the chain of evidence and assist the reviewer:

SIGNATURE:

_____

Executive Director/ CEO/ Facility Administrator (or Designee for Executive Director/ CEO/ Facility Administrator) Date Name of Person Completing Form

This document should be sent to:

Director of Quality Management, SCDDSN, PO Box 4706, Columbia, SC 29240, Fax #: 803.898.7450